MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • Obstetrics

November 2005 • Bulletin 376

Contents

Medi-Cal Training Seminars

CMC Claim Submission for Medicare/Medi-Cal Crossover Billers 1

FluMist is New VFC Benefit 1

Menactra is New VFC and Medi-Cal Benefit 2

DECAVAC is New VFC Benefit 2

Radiopharmaceutical Billing Update 3

Rate Adjustment for Laparoscopic Vaginal Hysterectomy 3

2006 ICD-9 Code Updates 4

Additional Reimbursement Criteria for Hepatitis 5

By Report Requirement Removed for Skin Debridement 5

Secondary Diagnosis Codes for Incontinence Supply Products 5

Family PACT: Family Planning Methods Discontinued 6

Family PACT: New Sterilization Consent Form for Providers 6

Inpatient Provider Cutoff for Non-HIPAA Electronic Claims 6

DUR: Appropriate Drug Billing Unit Standards 8

Medi-Cal List of Contract Drugs 10

CMC Claim Submission for Medicare/Medi-Cal Crossover Billers

Medi-Cal can now receive electronic crossover claims directly from approved submitters via the ASC X12N 837 v.4010A1 transaction. Submitters using the 837 format must include Medicare payment information at the detail/claim line level. Additionally, Medi-Cal can receive electronic crossover claims automatically from Mutual of Omaha and United Government Services Medicare intermediaries for most Part B services billed to Part A intermediaries. This new provision primarily affects outpatient and dialysis providers who were previously required to bill these claims on paper. Providers of Part B services billed to Part A intermediaries other than Mutual of Omaha and United Government Services must continue to bill their claims directly to Medi-Cal either on paper or in the new HIPAA standard 837 electronic transaction until a new automatic crossover process is established with the Medicare Consolidated Coordination of Benefits Contractor sometime in 2006.

In order to comply with HIPAA electronic standards, providers billing crossover claims on paper for Part B services billed to Part A intermediaries will be required to attach the detail/claim line level *National Standard Intermediary Remittance Advice* (Medicare RA) to a *UB-92 Claim Form* and comply with revised billing instructions. Any claims received after October 24, 2005 that do not comply with the new billing and attachment requirements will be returned to providers for correction before processing.

Providers may obtain detailed Medicare RAs by printing the "Single Claim" report, which can be accessed through the latest version of PC Print software, available free of charge. PC Print software and instructions are available on the United Government Services Web site (**www.ugsmedicare.com**) by clicking "Providers," then "EDI" and then the "PC Print Software" link. Providers should obtain the PC Print software from Medicare as soon as possible to ensure they can print the appropriate Medicare RAs.

FluMist is New VFC Benefit

Effective for dates of service on or after November 1, 2005, FluMist (influenza virus vaccine, live, for intranasal use) is a new Vaccines For Children (VFC) benefit. Medi-Cal reimburses VFC providers an administration fee for providing the FluMist injection. Until further notice, FluMist will be billed to Medi-Cal with CPT-4 code 90749 (unlisted vaccine/toxoid) with modifiers -SK and -SL.

FluMist is reimbursable only for healthy individuals 5 through 18 years of age who are close contacts of people with chronic health conditions. Providers must document in the *Reserved For Local Use* field (Box 19), or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for FluMist.

Please see **FluMist**, *page 2*

FluMist *(continued)*

Note: Retain this Article
Because code 90749 is being used to bill FluMist for a short time only, billing instructions are not being added to the provider manual. This article constitutes the official billing instructions for using code 90749 when billing FluMist and should, therefore, be retained by providers.

Looking Ahead
Early in 2006 unlisted code 90749 will be discontinued for billing the FluMist administration fee and this service will then be billed with CPT-4 code 90660 (influenza virus vaccine, live, for intranasal use). Modifiers -SK and -SL must still be used. Additional information and manual pages concerning the billing of FluMist will be released in a future *Medi-Cal Update*.

Menactra is New VFC and Medi-Cal Benefit

Effective retroactively to dates of service on or after May 27, 2005, Menactra (meningococcal vaccine) is a new Vaccines For Children (VFC) benefit. Medi-Cal reimburses VFC providers an administration fee for providing the Menactra injection. Until a dedicated CPT-4 code is announced, Menactra will be billed with CPT-4 code 90749 (unlisted vaccine/toxoid).

Menactra is a VFC benefit for recipients ages 11 through 18 years of age considered at high-risk for exposure to meningitis, such as those who are complement deficient, asplenic or living in close quarters such as college students in a dormitory. The Menactra administration fee is reimbursable when billed with modifiers -SL (VFC supplied vaccine) and -SK (members of high-risk populations).

Menactra also is a benefit of the Medi-Cal program. Under the Medi-Cal program Menactra is designated for use in recipients at high-risk who are between 19 and 55 years of age. Claims in this category are billed with modifier -SK.

For both children and adult recipients, providers must document in the *Reserved For Local Use* field (Box 19), or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for Menactra. In addition, providers must document in the patient's office record the reason that the recipient is considered high-risk.

Note: Retain this Article
Because code 90749 is being used to bill Menactra for a short time only, billing instructions are not being added to the provider manual. This article constitutes the official billing instructions for using code 90749 when billing Menactra and should, therefore, be retained by providers.

Looking Ahead
Early in 2006 unlisted code 90749 will be discontinued for billing the Menactra administration fee and this service will then be billed with CPT-4 code 90734 (meningococcal conjugate vaccine, serogroups A, C, Y and W-135 [tetravalent], for intramuscular use). Modifiers -SK and -SL will still be used as outlined above. Additional information and manual pages concerning the billing of Menactra will be released in a future *Medi-Cal Update*.

DECAVAC is New VFC Benefit

DECAVAC is a new benefit for the Vaccines For Children (VFC) program. Medi-Cal reimburses VFC providers an administrative fee for providing the DECAVAC injection. DECAVAC is a diphtheria and tetanus toxoid [Td] adsorbed that is preservative free for use in individuals 7 years of age or older. For an interim period, this drug will be billed with CPT-4 code 90749 (unlisted vaccine/toxoid) and modifier -SL (VFC-supplied vaccine) retroactive to dates of service on or after January 1, 2005.

When billing code 90749, providers must document in the *Reserved For Local Use* field (Box 19), or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for DECAVAC. At this time DECAVAC is not a benefit for Medi-Cal recipients ages 19 or older.

Please see **DECAVAC**, *page 3*

DECAVAC *(continued)*

A special timeliness override has been developed in the claims processing system for DECAVAC claims submitted with code 90749.

Note: Retain this Article
Because code 90749 is being used to bill DECAVAC for a short time only, billing instructions are not being added to the provider manual. This article constitutes the official billing instructions for using code 90749 when billing DECAVAC and should be retained by providers.

Looking Ahead
Early in 2006 unlisted code 90749 will be discontinued for billing the DECAVAC administration fee and this service will then be billed with CPT-4 code 90714 (diphtheria and tetanus toxoids [Td] adsorbed, preservative free, for use in individuals seven years of age or older, for intramuscular use). Modifier -SL must still be used. Additional information and manual pages concerning code 90714 will be released in a future *Medi-Cal Update*.

Radiopharmaceutical Billing Update

Effective for dates of service on or after December 1, 2005, providers must submit a report and a valid invoice justifying additional units when billing for CPT-4 code 78990 (provision of diagnostic radiopharmaceutical[s]) or CPT-4 code 79900 (provision of therapeutic radiopharmaceutical[s]). These codes were deleted with the 2005 HCPCS update, but will remain billable until further notice.

This information is reflected on manual replacement page radi onc 1 (Part 2).

Rate Adjustment for Laparoscopic Vaginal Hysterectomy

Effective for dates of service on or after December 1, 2005, reimbursement rates for laparoscopic vaginal hysterectomy codes have been adjusted. The following CPT-4 codes are affected by the rate adjustment:

CPT-4 Code	Description
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less
58552	with removal of tubes and/or ovary
58553	Laparoscopy surgical, with vaginal hysterectomy, for uterus greater than 250 grams
58554	with removal of tubes and/or ovary

In addition, the reimbursement rate for CPT-4 code 58550 was erroneously set but has been corrected. As a result of the error, providers billing this code received overpayments. Medi-Cal will not recoup payment from providers for the overpayments that resulted from the erroneous rate. Providers should reference the Medi-Cal Web site at **www.medi-cal.ca.gov** for current rate information.

2006 ICD-9-CM Diagnosis Code Updates

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after January 1, 2006. Providers may refer to the *2006 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptions.

Additions

259.50	276.50	276.51	276.52	278.02	287.30	287.31
287.32	287.33	287.39	291.82	292.85	327.00	327.01
327.02	327.09	327.10	327.11	327.12	327.13	327.14
327.15	327.19	327.20	327.21	327.22	327.23	327.24
327.25	327.26	327.27	327.29	327.30	327.31	327.32
327.33	327.34	327.35	327.36	327.37	327.39	327.40
327.41	327.42	327.43	327.44	327.49	327.51	327.52
327.53	327.59	327.8	362.03	362.04	362.05	362.06
362.07	426.82	443.82	525.40	525.41	525.42	525.43
525.44	525.50	525.51	525.52	525.53	525.54	567.21
567.22	567.23	567.29	567.31	567.38	567.39	567.81
567.82	567.89	585.1	585.2	585.3	585.4	585.5
585.6	585.9	599.60	599.69	651.70	651.71	651.73
760.77	760.78	763.84*****	770.10*****	770.11*****	770.12*****	770.13*****
770.14*****	770.15*****	770.16*****	770.17*****	770.18*****	770.85*****	770.86*****
779.84*****	780.95	799.01	799.02	996.40	996.41	996.42
996.43	996.44	996.45	996.46	996.47	996.49	V12.42
V12.60	V12.61	V12.69	V13.02	V13.03	V15.88	V17.81
V17.89	V18.9	V26.31	V26.32	V26.33	V46.13	V46.14
V49.84	V58.11	V58.12	V59.70**§**	V59.71****§**	V59.72****§**	V59.73†**§**
V59.74†**§**	V62.84	V64.00	V64.01	V64.02	V64.03	V64.04
V64.05	V64.06	V64.07	V64.08	V64.09	V69.5	V72.42**§**
V72.86	V85.0††	V85.1††	V85.21††	V85.22††	V85.23††	V85.24††
V85.25††	V85.30††	V85.31††	V85.32††	V85.33††	V85.34††	V85.35††
V85.36††	V85.37††	V85.38††	V85.39††	V85.4††		

Restrictions

*****	Restricted to ages 0 thru 1 year
******	Restricted to ages 10 thru 35 years
†	Restricted to ages 35 thru 55 years
††	Restricted to ages 18 thru 99 years
§	Restricted to females only

Inactive Codes

Effective for dates of service on or after January 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

276.5, 287.3, 567.2, 567.8, 585, 599.6, 770.1, 799.0, 996.4, V12.6, V17.8, V26.3, V58.1, V64.0

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

285.21, 307.45, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 728.87, 780.51, 780.52, 780.53, 780.54, 780.55, 780.57, 780.58

All manual replacement pages reflecting these ICD-9 code updates will be included in future *Medi-Cal Updates*.

Additional Reimbursement Criteria for Hepatitis A and B Combo

Effective for dates of service on or after December 1, 2005, CPT-4 code 90636 (hepatitis A and hepatitis B combination vaccine) is reimbursable for any recipient 19 years of age or older who is at risk of developing hepatitis A and/or hepatitis B due to the following:

- Receives blood factor products, either for the treatment of a medical disorder or as an occupational exposure
- Has chronic liver disease
- Had a liver transplant
- Uses illicit injectable or non-injectable "street" drugs
- Is a male having sex with other males
- Individuals in high risk situations, such as day-care centers, hemodialysis units, drug and alcohol treatment centers, correctional facilities and places where emergency medical assistance is rendered
- Has come in contact with blood, body fluids, feces or sewage
- Has come in contact with live hepatitis A and/or B virus

The updated information is reflected on manual replacement page inject 48 (Part 2).

'By Report' Requirements Removed for Skin Debridement Service

"By Report" requirements are removed for podiatrists and assistant surgeons who submit claims for CPT-4 code 11040 (debridement; skin, partial thickness). Podiatrists require an approved *Treatment Authorization Request* to be reimbursed for this service. These policy changes are effective for dates of service on or after December 1, 2005.

Secondary Diagnosis Codes for Incontinence Supply Products Updates

The following updates for billing incontinence supply products are effective for dates of service on or after December 1, 2005:

- ICD-9 code 788.38 (overflow incontinence) is added to the list of codes accepted as the secondary diagnosis.
- ICD-9 code 788.3 (urinary incontinence) is removed from the list of acceptable secondary diagnosis codes, and will be denied if included on claims.

The updated information is reflected on manual replacement page hcfa comp 13 (Part 2).

Family Planning Methods Discontinued

Effective immediately the following Family PACT (Planning, Access, Care and Treatment) benefits are discontinued.

HCPCS Code	Description
X1512	Intrauterine device (IUD) (generic code)
X1514	Progestasert intrauterine device
X1520	Levonorgestrel contraceptive implant (Norplant)
X7490	Medroxyprogesterone acetate and estradiol cypionate (Lunelle)
X7720	Levonorgestrel/ethinyl estradiol/pregnancy kit (Preven)

These family planning methods are no longer available for purchase in the United States. The generic IUD has been replaced by specific codes for currently available intrauterine devices. Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, providers may call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

New Sterilization Consent Form for Family PACT Providers Coming Soon

Begin using the PM 330 now for sterilizations scheduled on or after February 1, 2006.

Effective for dates of service on or after February 1, 2006, claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 55250, 58600, 58615, 58670, 58671, 00851 or 00921) must adhere to all Medi-Cal policies described in the *Sterilization* section of the Part 2 provider manual, including submission of a Department of Health Services sterilization *Consent Form* (PM 330). Use of the PM 330 also includes the following policy updates:

- Recipients must be a minimum of 21 years of age.
- A minimum 30-day waiting period between the recipient's consent and the date of the sterilization procedure is required.

Claims for elective sterilization from Family PACT providers for dates of service prior to February 1, 2006 must continue to follow current Family PACT policy as applied to the sterilization *Consent Form* (PM 284).

Revised *Family PACT Policies, Procedures and Billing instructions* (PPBI) will be issued in a future *Updated Information*. For more information regarding Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555.

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claim Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal is planning to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Self-Service HIPAA Transaction Utility Tool
A self-service environment, HIPAA Transaction Utility Tool, will soon be available for submitters. Initially, the utility tool will be available only for inpatient submitters to validate ASC X12N 837 v.4010A1 transactions in preparation for proprietary format discontinuance. However, the utility tool will become available to other submitter communities as their timeline for proprietary format discontinuance is determined.

Please see **Inpatient Provider Cutoff Date**, *page 7*

Inpatient Provider Cutoff Date *(continued)*

The utility tool will offer transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Inpatient submitters have been notified of the utility tool's availability via e-mail or letter depending on information availability.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

DRUG USE REVIEW
Educational Information

Appropriate Drug Billing Unit Standards for Medi-Cal

Each time a drug is billed to Medi-Cal, the claim must state how much of the drug was provided. Knowing which unit measurement to use allows for proper reimbursement and decreases the likelihood of the provider being under- or over-paid. This article summarizes the National Council on Prescription Drug Programs (NCPDP) Billing Unit Standards, provides examples of common billing unit errors, and briefly discusses how physicians and clinics bill for drugs.

I. Pharmacies

Pharmacy claims follow a standard set of rules established by NCPDP. These rules are summarized below.

Table 1: Adapted from NCPDP Billing Unit Standards Version 2.0

Dose Form	Proper Unit of Measurement
• Tablet (including convenience packs or oral contraceptive packs) • Capsule (including convenience packs) • Transdermal Patch • Suppository • Non-filled Hypodermic Syringe	• Each Tablet • Each Capsule • Each Transdermal Patch • Each Suppository • Each Non-filled Hypodermic Syringe
• Kit • Powder Packet • Vial with Powder • Non-drug Products (test strips, swabs, alcohol wipes) • Tape	• Each Kit • Each Powder Packet • Each Vial with Powder • Each actual non-drug item in the container • Each Tape
• Liquid (elixir, syrup, ophthalmic/otic liquids, bulk liquids, etc.) • Reconstitutables (the volume in the container after the powder has been reconstituted into a liquid) • Liquid Pre-filled Syringes • Vial/Ampule with Liquid • Inhalers, Nebulized Solutions (when labeled as mL on product)	• mL or cc ➢ in the exact metric quantity, not rounded off
• Solid (ointment, cream, bulk powder, etc.) • Inhalers (when labeled as mcg, mg or gm on product)	• gm ➢ in the exact metric quantity, not rounded off to whole numbers ➢ mcg is converted to gm

Please see **Appropriate Drug Billing Unit Standards**, *page 8*

Appropriate Drug Billing Unit Standards *(continued)*

Exceptions to NCPDP Billing Unit Standards
The following products are current exceptions to the general rules regarding billing unit standards. These products must be billed in units measured per each or eaches.

- EpiPen *1 each*
- Imitrex Kit Refill *1 each*
- Prevpac *14 eaches*
- Helidac *56 eaches*
- Pravigard *30 eaches*

Inhalers: As stated in the rules, use the unit of measurement listed on the product. If both volume and weight are listed on the product, then use the first unit listed. For example, if the package states "14 gm (10 mL)," then 14 grams is used. If the product weight is listed in terms of mcg or mg, the billing unit is converted to gm. Please note that Pulmicort Turbuhaler is an exception to this rule and is billed as "each."

Rounding Off: Do not round off. If the quantity is not a whole number, then submit the quantity in the metric decimal form. For example, a 3.5 gm tube of ointment should be expressed as 3.500, rather than rounding to 4. Do not include measurement units such as gm or cc. For more information on rounding, see the *Pharmacy Claim Form (30-1) Completion* section in the provider manual.

Kits: A kit must be billed as each kit rather than as separate components or according to units of measurement. Kits have at least two different items in the same package, intended for dispensing as a unit, and the kit has a single NDC number. The two items may or may not be drugs. Below are three different types of kits:

1. Two drug items that each have a different billing unit standard (example: tablet and liquid)
2. One drug plus alcohol swab or cotton (example: Copaxone)
3. Meter plus test strips

Proprietary Computer Systems: Some computer systems convert the units that an operator enters. For example, a "1" is entered for a four-ounce bottle of cough syrup and the computer system converts it to "120" because the bottle size is 120mL. Medi-Cal has identified claims submitted for 14,400 units (mL) because the quantity entered was "120" and the pharmacy's computer multiplied that by 120 for a total of 14,400 mL.

Table 2: Examples of Erroneous Billing

Quantity Dispensed	Examples of Erroneous Billing	Type of Error	Correct Billing Unit
Duragesic 50 mcg/hr Patches 1 box, 5 patches per box	"10" for 10 days supply	Over-billing	5 patches
	"1" for 1 box	Under-billing	5 patches
Augmentin 200mg/28.5 mg/5mL Suspension 1 bottle of 100 mL	"200" for 200 mg	Over-billing	100 mL
	"1" for 1 bottle	Under-billing	100 mL
Lovenox 30mg/0.3mL Pre-Filled Syringes 12 syringes of 0.3 mL	"12" for 12 pre-filled syringes	Over-billing	3.6 mL
	"4" for 3.6 mL rounded up to the nearest whole number	Over-billing	3.6 mL

Please see **Appropriate Drug Billing Unit Standards**, *page 9*

Appropriate Drug Billing Unit Standards *(continued)*

Quantity Dispensed	Examples of Erroneous Billing	Type of Error	Correct Billing Unit
Humalog 100U/mL 1 vial of 10 mL	"1" for 1 vial	Under-billing	10 mL
	"1000" for 1000 units	Over-billing	10 mL
Copaxone Pre-Filled Syringe Solution for Injection Kit 1 box (kit) of 30 pre-filled syringes	"30" for 30 pre-filled syringes	Over-billing	1 kit
	"30" for 30 mL (1 mL per pre-filled syringe)	Over-billing	1 kit

II. Physicians and Clinics

Injection Codes
There are codes for claims submitted by physicians and clinics for drugs administered to recipients. These codes do not necessarily follow NCPDP rules. Therefore, providers must look up the product in the list of codes for injections in the appropriate Part 2 provider manual. The injection codes are also listed in the following two ways:

1. Injection codes are listed in the *Injections: List of Codes* section of the appropriate Part 2 provider manual.
2. Injection codes may also be found on the Medi-Cal Web site, **www.medi-cal.ca.gov**. Go to the "Provider Manuals" section located on the right side of the Medi-Cal Web site home page. Click "Inpatient/Outpatient." On the "Inpatient/Outpatient Provider Manual" page, locate the link for the appropriate Part 2 provider manual. Click on that link. Scroll down the provider manual subject list until you find the link for "Injections: List of Codes." Click the link to view the list of injection codes.

Physician and Office-Administered Injection Pricing
The maximum amount payable for the first unit is the cost of the drug plus an administration fee. For quantities greater than one unit, the cost of the additional units is added to the amount payable for the first unit. The price per unit published by Medi-Cal is the price for the first unit (including the administration fee).

Providers may look up current Medi-Cal maximum reimbursement rates on the Medi-Cal Web site, **www.medi-cal.ca.gov**. Go to the "Provider Reference" section on the left-hand side of the home page. Click "Medi-Cal Rates." On the "Medi-Cal Rates" page, either click "Download All Medi-Cal Rates" or "View Medi-Cal Rates by Procedure Code." To search rates by procedure code, click the link displaying the code range with the code you are searching for.

Conclusion
Incorrect billing practices generate erroneous payments and skew utilization information, which may trigger an audit review of provider claims and/or an investigation into possible fraudulent activity. To avoid these outcomes and to increase the likelihood of correct claims processing and payment, providers should pay close attention to drug billing unit standards when they submit claims for reimbursement.

Please refer to pages 36-22 thru 25 in the Medi-Cal Drug Use Review Manual.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications.*

Additions, effective November 1, 2005

Drug	Size and/or Strength
ALENDRONATE SODIUM/CHOLECALCIFEROL	
+ Tablets	**70 mg/2800 IU**
LOTEPREDNOL ETABONATE/TOBRAMYCIN	
Ophthalmic suspension	**0.5 %/0.3 %**

Changes, effective November 1, 2005

Drug	Size and/or Strength	
ALENDRONATE SODIUM		
Oral solution	**70 mg/75 cc**	
+ Tablets	5 mg	
	10 mg	
	35 mg	
	40 mg	
	70 mg	
CLINDAMYCIN PHOSPHATE		
‡ Injection	150 mg/cc	2 cc
		4 cc
		6 cc
		60 cc
Vaginal cream	**2 %**	**5.8 Gm**
Topical solution	1 %	60 cc
IRBESARTAN AND HYDROCHLOROTHIAZIDE		
+ Tablets	150 mg – 12.5 mg	
	300 mg – 12.5 mg	
	300 mg – 25 mg	
‡ ***** ZIDOVUDINE		
Tablets	300 mg	
Capsules	100 mg	
Liquid	50 mg/5cc	
Injection	10 mg/cc	

* Restricted to use as combination therapy in the treatment of Human Immunodeficiency Virus (HIV) infection.

(NDC labeler code 00173 [GlaxoSmithKline] only.

\+ Frequency of billing requirement

Please see **Contract Drugs**, *page 11*

Contract Drugs *(continued)*

Changes, effective January 1, 2006

Drug	**Size and/or Strength**	
CLINDAMYCIN PHOSPHATE		
* Vaginal cream	2 %	40 Gm
*** Prior authorization always required.**		
* Vaginal suppositories		1 Gm
*** Prior authorization always required.**		

Instructions for Manual Replacement Pages — Part 2

November 2005

Obstetrics Bulletin 376

Remove and replace:	hcfa comp 13/14 inject 47/48
Remove:	inject 53
Insert:	inject 53/54 *(new)* *
Remove and replace:	radi onc 1/2 surg bil mod 5/6 *

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-21
Insert:	36-21 thru 25 *(new)*

* Pages updated due to ongoing provider manual revisions.